STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED	
		155582	B. WIN			09/27/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .		l	VASHINGTON ST		
MILLER'S	S MERRY MANOR				RUSA, IN46573		
			1			1	
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		EACH DEFICIENCY MUST BE PERCEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
F0000							
				000	Diagon assert this DOC as a		
	This visit was for the investigation of		FO	000	Please accept this POC as o credible allegation of complia		
	Complaint IN000	095676.			The facility respectfully reque		
					face to face IDR for F-tag 31		
	Complaint IN000	095676: Substantiated,					
		ficiencies related to the					
		ited at F312, F282 and					
	F314.	100 at 1 5 12, 1 202 and					
	1314.						
	Survey dates: 9/2	26 and 9/27/11					
	Facility number:	000521					
	Provider number	: 155582					
	Aim number: 10	00266980					
	Survey Teem: E	Illen Ruppel, RN, TC					
	<u>-</u>						
	Ann Armey, RN						
	Carol Miller, RN	1 (9/27/11)					
	Census bed type:	:					
	SNF: 17						
	SNF/NF: 102						
	Total: 119						
	117						
	Conque nerven +	20:					
	Census payor typ	DE.					
	Medicare: 9						
	Medicaid: 88						
	Other: 22						
	Total: 119						
	Sample: 7						
	Campic.						
	Those deficients	es also reflect state					
	i nese denciencio	es also leffect state					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155582			(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  OO	(X3) DATE SURVEY COMPLETED 09/27/2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE VASHINGTON ST RUSA, IN46573	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	The services provifacility must be proin accordance with plan of care. Based on observarecord review, the physician's or vitamin/iron/min 4 residents in a sar Resident #B  Findings include The clinical recordeviewed, on 9/2 indicated the residents.	ded or arranged by the ovided by qualified persons a each resident's written ation, interviews and e facility failed to follow orders for administering a eral supplement for 1 or ample of 7.  The definition of the facility failed to follow orders for administering a eral supplement for 1 or fample of 7.  The definition of the facility failed to facility failed by the facility failed to facility failed by the facility failed for a facility failed by the facility failed for a facil	F0282	It is the policy of Miller's Mendanor, Wakarusa that service provided or arranged by the facility be provided by qualification of care. Resident # B: The order Multivitamin with iron was received on 8/29/2011. The pharmacy called the facility asked that the order be clarification. A clarification order was written, but the pharmacy nearly the pharmacy nearly was the clarification. On 9/16/2011 the facility received the clarification. On 9/16/2011 the facility received the multivitamin with iron/mineral and have been administering daily as ordered. All future physician orders for resident be implemented and followed plan of care. All residents are	ces  ied each er for and ified s and as ever n ed the als g

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155582 09/27/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 300 N WASHINGTON ST MILLER'S MERRY MANOR WAKARUSA, IN46573 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE risk to be affected by the deficient practice. The facility nurse Review of the physician's orders, managers completed an audit of indicated the physician had ordered a all MAR's and TAR's on complete blood count, on 8/28/11. The 9/27/2011 to ensure that each resident is getting meds and report indicated the residents white count treatments as ordered by was high at 11.95 (normal 4.0-11.0), the physician. An all staff in-service red blood cell count was low at 3.89 with all staff who administer (normal 3.9-5.9), the hemoglobin was low medications/treatments will be at 10.8 (normal 13.0-17.3) and the held on or before 10/26/2011 and the facility policy for "New hematocrit was low at 34.5 (normal Orders" (attachment A), "Monthly 39.0-53.0). The physician had ordered Consolidated Orders" multivitamins with minerals and iron, on (Attachment B), "Physicians 8/29/11. Order Transcription Procedure" (Attachment C) will be reviewed. The charge nurses will be Review of the Medication Administration instructed in the event a Record (MAR) for the months of August medication or treatment is not available the facility pyxis and September, 2011, indicated the machine will be accessed and a medication had been circled or not given phone call will be made to the 13 of 17 days from 8/29 to 9/15/11. The pharmacy. The charge nurse will information on the back of the MAR also be responsible to indicate on indicated the vitamin was not available. the 24hour report tool that the pvxis machine had to be accessed to obtain needed med During an interview with the Director of or treatment. If the medication or Nursing (DoN) on 9/27/11 at 11:00 a.m., treatment is not available in the she indicated she had not been made facility pyxis machine the pharmacy will be contacted and aware the medication was not being given instructed to send from the and had checked with the pharmacy. The back-up pharmacy. The charge DoN indicated the pharmacy told her they nurse will also be responsible to had not received the order, and the contact the DON or other nursing designee to notify that the item is vitamins had not been sent until the nurse not available and that the back up called on 9/15/11. The DoN checked the pharmacy is suppose to deliver. (emergency drug system) and found the The charge nurses will be vitamin had been available in the facility, instructed to administer upon receipt of needed but had not been taken out for Resident

MILLER'S MERRY MANOR  (X4) ID PREETX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  REVIEW of a second hemoglobin and hematocrit, ordered by the physician to be done 9/12/11, after the vitamin/mineral/iron supplement had been administered for a two week period, indicated the hemoglobin remained at 10.8 and the hematocrit was slightly better at 34.8.  This rederal tag relates to Complaint IN00095676.  3.1-35(g)(2)  This rederal tag relates to Complaint In00095676.  3.1-35(g)(2)  Tradition of the provided	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155582			ULTIPLE COI LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
MILLER'S MERRY MANOR  (X4) ID  PREFIX TAG    SLMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR ISC IDINITIPYING INFORMATION)    #B.			155562	B. WIN	G		09/2//2	011
SUMMARY STATEMENT OF DEFICIENCES   TAG   PREFIX   CEACH DEFICIENCY MUST BE PERCEDED BY FULL   PREFIX   TAG   PREFIX   TAG   PREFIX   PRE				300 N WASHINGTON ST				
#B.  Review of a second hemoglobin and hematocrit, ordered by the physician to be done 9/12/11, after the vitamin/mineral/iron supplement had been administered for a two week period, indicated the hematocrit was slightly better at 34.8.  This federal tag relates to Complaint IN00095676.  3.1-35(g)(2)  FOSS-BEREPENDO TO RE-PROPRIATE CONSMILLION DATE  PREFIX PROPRIATE CONSMILLION PROPRIATE CONSMILLION DATE  PREFIX PROPRIATE CONSMILLION DATE  COMPLETION DATE  COMP								
#B.  Review of a second hemoglobin and hematocrit, ordered by the physician to be done 9/12/11, after the vitamin/mineral/iron supplement had been administered for a two week period, indicated the hemoglobin remained at 10.8 and the hematocrit was slightly better at 34.8.  This federal tag relates to Complaint IN00095676.  3.1-35(g)(2)  This federal tag relates to Complaint Inwoops of the physician order designee will be responsible to complete the QA tool tittled "Physician Order designee will be responsible to complete the QA tool tittled "Physician Order Review" (Attachment J) on all new orders daily for the next 6 months to ensure medications and treatments are administered per order. The QA tool "Physician Order Review" will also include MARTAR review 3x weekly for one and the sufficient of the provision of the delivered as ordered. Any identications and treatment orders are available and delivered as ordered. Any identified issues will be logged on a QA tracking log and reviewed during the monthly facility QA meeting to monitor for ongoing compliance.						PROVIDER'S PLAN OF CORRECTION		
#B.  Review of a second hemoglobin and hematocrit, ordered by the physician to be done 9/12/11, after the vitamin/mineral/iron supplement had been administered for a two week period, indicated the hemoglobin remained at 10.8 and the hematocrit was slightly better at 34.8.  This federal tag relates to Complaint IN00095676.  3.1-35(g)(2)  This federal tag relates to Complaint Innewords and include the Aphysician ordered the Unit managers or other designee will be responsible to complete the QA tool titled "Physician Order Review" (Altachment J) on all new orders daily for the next 14days, then on 10 new physician orders for each seperate unit weekly for 30days, then 10 new orders weekly for the next 6 months to ensure medications and treatments are administered per order. The QA tool "Physician Order Review" will also include MAR/TAR review 3x weekly to ensure medications and treatment orders are available and delivered as ordered. Any identified issues will be logged on a QA tracking log and reviewed delivered as ordered. Any identified issues will be logged on a QA tracking log and reviewed uning the monthly facility QA meeting to monitor for ongoing compliance.		``				CROSS-REFERENCED TO THE APPROPRIAT	ΓE	
Review of a second hemoglobin and hematocrit, ordered by the physician to be done 9/12/11, after the vitamin/mineral/iron supplement had been administered for a two week period, indicated the hemoglobin remained at 10.8 and the hematocrit was slightly better at 34.8.  This federal tag relates to Complaint IN00095676.  3.1-35(g)(2)  This federal tag relates to Complaint Inough the physician orders depth the physical order depth the pysis machine has been accessed will be reviewed by nurse manager to ensure medication/treatment was delivered as ordered. The unit managers or other designee will be responsible to complete the QA tool titled 'Physician Order Review' (Attchment J) on all new orders daily for the next 14days, then on 10 new orders weekly for 30days, then 10 new orders weekly for meat 6 months to ensure medications and treatments are administered per order. The QA tool "Physician Order Review" will also include MAR/TAR review 3x weekly to ensure that existing medication and treatment orders are available and delivered as ordered. Any identified issues will be logged on a QA tracking log and reviewed during the monthly facility QA meeting to monitor for ongoing compliance.	TAG		LSC IDENTIFYING INFORMATION)		IAG	·		DATE
to maintain good nutrition, grooming, and personal and oral hygiene.	F0312 SS=D	Review of a seconhematocrit, order done 9/12/11, aft vitamin/mineral/sadministered for indicated the hem at 34.8.  This federal tag is IN00095676.  3.1-35(g)(2)	unable to carry out activities ves the necessary services putrition, grooming, and			otherwise contraindicated. T DON or other nursing design will follow up to ensure that medication/treatment is made available and administered a ordered by the physician. Th 24hour report tool will serve a communication device that is reviewed routinely by the nur managers and any notation to the pyxis machine has been accessed will be reviewed by nurse manager to ensure medication/treatment was delivered as ordered. The uni managers or other designee be responsible to complete th QA tool titled "Physician Order Review" (Attachment J) on al new orders daily for the next 14days, then on 10 new phys orders for each seperate unit weekly for 30days, then 10 n orders weekly for the next 6 months to ensure medication and treatments are administe per order. The QA tool "Physician Order Review" wil include MAR/TAR review 3x weekly to ensure that existing medication and treatment ord are available and delivered a ordered. Any identified issue be logged on a QA tracking le and reviewed during the mon facility QA meeting to monito	eee ee ee s see eas a f see hat  t will he er ll sician f eew s ered l also g ders s es will og hthly	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155582	B. WIN		<del></del>	09/27/2	011
		<u> </u>	F1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			WASHINGTON ST		
MILLER'	S MERRY MANOR				RUSA, IN46573		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	, i	NCY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
	Based on observation, interviews and		F0	312	It is the policy of Miller's Mer		10/27/2011
	record review, the facility failed to provide care and service to promote the toileting for residents. This deficiency				Manor, Wakarusa that ADL care is provided to a resident who is		
					unable to carry out activities		
					daily living receives the nece		
		esidents in a sample of 7.			services to maintain good	, , , , , , , , , , , , , , , , , , ,	
	(Residents #G, #	•			nutrition, grooming, and pers	sonal	
	(Residents #G, #	and #C)			and oral hygiene.Resident		
	Fig. 41				#G,#H,#C: The HCP team h		
	Findings include	<del>.</del>			reviewed and updated plans		
					care. Nursing assignment s updated to reflect HCP spec		
		3:05 p.m., LPN #1			interventions for toileting nee		
	indicated Resident #G was incontinent at				The facility will provide ADL		
	times and requir	ed assistance to use the			as identified in each individu		
	bathroom.				residents plan of care. All		
					residents are at risk to be		
	On 9/26/11, bety	ween 3:10 p.m. and 7:05			affected by the deficient		
		G was observed and was			practice. The nurse manage other designee will review the		
	1 *	bathroom or toileted.			ADL care needs of depende		
		Resident #G included but			residents and update/review		
					current plan of care. The C.I		
		to, the following:			assignment sheets serve as		
		e resident was sleeping in			communication device for di		
		unit and was holding a			care staff to know the specif		
		to summon help.			toileting needs of individualize residents. An all staff	<del>Le</del> u	
	At 4:00 p.m., the	e nurse spoke to the			nursing meeting will be held	on or	
	resident but she	continued to sleep.			before 10/26/2011 to discus		
	At 4:30 p.m., the	e resident continued to			facility policy and procedure	s for	
	_	ner holding the bell.			"Skin Management Procedu	res"	
	_	e resident continued to			(Attachment D), "Bowel and		
	sleep in the recli				Bladder Assessment and Elimination" (Attachment E),	and	
					resident care topics from the		
	At 5:30 p.m., the resident was transferred to a wheelchair and taken directly to the dining room.				"Basic Nurse Aide Program"		
					caring for dependent resider		
					will be reviewed. The charg	е	
	1 -	e resident was being			nurses will be responsible to		
		the main dining room.			make routine walking rounds		
	At 6:10 p.m., the	e resident was returned to			the units they are assigned t	U	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155582	A. BUI	LDING	00	09/27/2	
		100062	B. WIN			09/2//2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MILLER'	S MERRY MANOR		300 N WASHINGTON ST WAKARUSA, IN46573				
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PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
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	the unit in her w	heelchair.			monitor that toileting care is		
	At 6:40 p.m., the	e resident continued to sit			delivered as outlined in each individual residents plan of c		
	in her wheelchai	r on the unit but had			The unit managers or other	arc.	
	pulled off her wi	g.			designee will be responsible	to	
	At 7:05 p.m., the	e resident continued to sit			update C.N.A. assignment sh		
	in the wheelchair	r on the unit and no			with any changes in plan of on promptly to ensure direct car		
	attempt was mad	le to toilet or take			staff have HCP information to		
	Resident #G to the	he bathroom to be			deliver needed care to deper		
	checked or chang	ged.			residents. The nurse		
					management team will also r walking rounds of the facility		
	The clinical reco	ord of Resident #G was			all three shifts randomly for t		
	reviewed on 9/27	7/11 at 9:30 a.m., and			next 10days to ensure the		
	indicated the resi	ident was admitted to the			toileting of dependent reside		
	facility on 6/17/1	1, with diagnoses which			implemented per plan of care		
	included but wer	e not limited to, paralysis			facility nurse managers or othe designees will complete the Q		
	agitans, and hype	ertonicity of bladder.			tool "Care Plan Review"  (Attachment F) and "Bowel a		
	The Opertarity M	IDS (Minimum Data Set)			Bladder Incontinence Review		
	1	ed 9/23/11, indicated the			(Attachment G) weekly for th	е	
		oderately impaired			next 6 weeks on at least 20		
		, required extensive			residents each week, then monthly thereafter to ensure		
	_	insfer/toileting and was			ongoing compliance. Any		
		tinent of bladder.			identified trends or issues wil	l be	
	inequently incom	ment of bladdel.			immediately corrected and lo		
	The care plan in	itiated 6/17/11, indicated			on facility tracking log. Track log will be reviewed during th		
		s incontinent of bowel and			monthly QA meeting to ensu		
		potential for skin			ongoing compliance.		
		care plan indicated					
		and/or check and change					
	every 2 hr (hours	•					
	1,01, 2 m (mount	- <i>)</i> -					
	On 9/27/11 at 1::	30 p.m., Resident #G was					
	observed being t	oileted by CNAs #3 and					
	#4. The resident'	s buttock was red and a					

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	PROVIDER OR SUPPLIER	2	<u> </u>	300 N W	DDRESS, CITY, STATE, ZIP CODE VASHINGTON ST USA, IN46573		
				<u> </u>			
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	perineal barrier ointment was applied.						
	indicated Reside	t 3:05 p.m., LPN #1 nt #H was incontinent at ed assistance to use the					
	p.m., Resident # not taken to the Observations of were not limited At 3:20 p.m., the a recliner on the blanket. Her sho At 4:00 p.m., the sleep in the recli At 4:20 p.m., the take medicine.	veen 3:20 p.m. and 7:05 H was observed and was bathroom or toileted. Resident #H included but to, the following: e resident was sleeping in unit covered by a less were on the floor. e resident continued to mer. e resident was awaken to					
	sleep in the recli At 5:20 p.m., the on her feet and s wheelchair and t dining room. At 5:45 p.m., she main dining room At 6:40 p.m., the the unit in her w At 6:45 p.m., the crackers and a sl crackers. At 7:00 p.m., the	ner. e resident's shoes were put he was transferred to a aken directly to the e was eating fruit in the m. e resident was returned to					

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155582			LDING	NSTRUCTION 00	(X3) DATE COMPL 09/27/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON ST WAKARUSA, IN46573					
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		s not toileted or taken to fore or after the evening						
	queried about no The CNA indicar asked to use the he had not taken. The clinical recording reviewed on 9/27 indicated the residual facility on 4/27/1 included but were dementia, orthood diabetes mellitus. The Quarterly Massessment, date resident had sever required extensive transfer/toileting occasionally incomplete the conditional facility of the conditional faci	tatic hypotension and a						
	#C was reviewed	inical record of Resident d, on 9/26/11 at 3:30 p.m., e had been admitted to the						

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	S MERRY MANOR			<u> </u>	RUSA, IN46573		
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	facility on 7/28/11. Her diagnoses included but were not limited to:						
	included, but were not limited to: dementia, cerebrovascular accident						
	1						
	(stroke), diabetes and Whipple procedure						
	for cholangiocarcinoma.						
	The MDS assess	sments, of 8/15/11 and					
	8/23/11, indicate	ed she was totally					
	dependent for ac	tivities of daily living.					
	Admission orders included Jevity tube						
	feedings via gastrostomy tube and care of						
	a Foley urinary						
	Care plan interv	entions, dated as initiated					
	_	ed "Assist to bedside					
		juest." The resident was					
		ate stool softener 150 mg					
	_	een observed by nurses,					
		01 (11:01 p.m.) to have					
		th scant bleeding.					
	inomormoids, wi	an seam ofecame.					
	Nurses notes, da	ted 8/7/11 at 07:24 a.m.,					
	-	resident's) son requested					
		bathroom at 945pm					
	(sic), CNA's too	k res to bathroom where					
	res had small BN	M (bowel movement), at					
	11pm res son red	quested for res to be taken					
	to bathroom aga	in, CNA explained to son					
	that res could be	taken to bathroom every					
	two hours, res so	on stated 'that wont (sic)					
	do, I want to talk	to the nurse.' This nurse					
		d tried explaining to son					
		taken to bathroom every					
	Litat 105 Coura DC	mach to outhouth every					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155582		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL 09/27/20	ETED		
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	her something to dont (sic) take he nurse explained to something to 'ma a stool softener to so she does not g stated that if she bathroom he wou this time it was 1 to bathroom and	plied 'if you are giving make her go and you er that is abuse.' This hat res was not given ke her go', res was given to help soften her stools et impacted. Res son was not taken to the ald seek legal help. At 130pm and res was taken had no results."						
F0314 SS=D	a resident, the faci resident who enter pressure sores do sores unless the ir demonstrates that a resident having p necessary treatment healing, prevent in sores from develop Based on observati record review, the implement an intervitamin/iron/min promote healing	ation, interviews and e facility failed to	F0	314	It is the policy of Miller's Merr Manor, Wakarusa to provide treatment and services that prevent the development of pressure sores unless the individual's clinical condition demonstrates that they were	у	10/27/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		155582	A. BUI. B. WIN			09/27/2	011
			B. WIN		DDDECC CITY CTATE ZID CODE		
NAME OF F	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
MULTER!	2 MEDDY MANOR				VASHINGTON ST		
MILLERS	S MERRY MANOR			WAKAR	RUSA, IN46573		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	1 or 4 residents i	n a sample of 7, who was			unavoidable; and a resident		
		reakdown. Resident #B			having pressure sores receiv		
	***************************************				necessary treatment and ser	vices	
	Dia dia an in da da				to promote healing, prevent		
	Findings include				infection, and prevent new so		
					from developing.Resident #B	: An	
	The clinical reco	ord of Resident #B was			order for Multivitamin with	<b>n</b>	
	reviewed, on 9/2	7/11 at 10:05 a.m., and			minerals/iron was received o 8/29/2011. The resident did		
	indicated the res	ident had been admitted			have a pressure area at the t		
	to the facility on	8/19/11. His diagnoses			the multivitamin with minerals		
	included, but we	•			was ordered. The multivitam	iin	
	· · · · · · · · · · · · · · · · · · ·				with minerals/iron has been o	given	
		accident, hypertension			daily as ordered since 9/16/2	011.	
	and hemiplegia.				A skin risk assessment was		
					completed at admission per		
	The admission as	ssessment, dated 8/19/11			facility policy. Head to toe ski	in	
	and a subsequent	t assessment on 9/18/11			assessments completed per	dont	
	•	ident had no skin			licensed nurse weekly. Resignate had pressure relieving device		
		initial observation date			place on bed and in wheelch		
					admission. Resident had a	an at	
		n Data Set (MDS)			specific HCP for the preventi	on of	
	•	d 8/30/11, indicated the			pressure ulcer development		
	resident was at r	isk for skin breakdown			all interventions were followe	d per	
	due to being tota	lly dependent for			plan of care and the interven	tion	
	transfers, in need	l of extensive assistance			of multivitamin/minerals/iron	was	
	· · · · · · · · · · · · · · · · · · ·	non-ambulatory, needing			not included in plan for the		
		nce for eating and being			prevention of pressure ulcers	3.	
					All residents are at risk to be	tion	
		sive assistance for			affected by the deficient prac	tice.	
		sonal hygiene. The MDS			The facility nurse managers completed an audit of all MA	R's	
	also indicated he	was impaired on one			and TAR's on 9/27/2011 to		
	side both with up	oper and lower			ensure that each resident is		
	extremities. The	assessment indicated he			getting meds and treatments	as	
	was continent of	bowel and had a Foley			ordered by physician. An all		
		e. The 8/30/11, MDS			in-service with all staff who		
	indicated no skir				administer		
	mulcated no skir	I UICAKUUWII.			medications/treatments will b		
					held on or before 10/26/2011	and	
	The initial care p	olan, dated 8/19/11,			the facility policy for "New		

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR  MARAUSA, IN46573  DAY MAKARUSA, IN46573  MAKARUSA, IN46573  MAKARUSA, IN46573  MAKARUSA, IN46573  DAY MAKARUSA, IN46573  MAKARUSA, IN46573  DAY MAKARUSA, IN46573  MAKARUSA, IN46573  MAKARUSA, IN46573  DO YMASHINGTON ST  WAKARUSA, IN46573  DAY MAKARUSA, IN46573  DO YMASHINGTON ST  WAKARUSA, IN46573  MAKARUSA, IN46573  DAY MAKARUSA		STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY COMPLETED	
MILLER'S MERRY MANOR  (A4) ID SEMMARY STATEMENT OF DEFICIENCIS TAG SEQUENCES OF SECTION MUST BE PERCEDED BY FULL TAG indicated the interventions for prevention of skin breakdown were:  "*Skin assessment at least weekly by nurse *Provide pressure reducing device to chair *Encourage meal/fluid intake and record *Monitor labs as available *Serve diet as ordered *Provide pressure as needed *Monitor skin daily during care *notify physician and family of any change in skin integrity *Remind or assist to turn at least every 2 hr *Skin assessment upon admission and then every shift for the first 3 days *Assist to toilet & for check and change at least every 2 hr *Provide a 4 oz vitamin C enriched juice daily *Offer two entree selections every meal. In addition, use the always available alternate list as needed *Provide a well balanced diet that meets 100% of the RDT's & an minimum of 2000 calorics, 80 GM of protein, 1500 ml of fluid *Provide a nourishing HS (hour of sleep) snack *Assess food likes and dislikes *Assess food likes and dislikes  *Provide a vent balanced diet that *Provide a well balanced diet that meets and the company in the physician. *Assess food likes and dislikes  *Tag  **ID **MONTOR** **CATL PROVIDENT ON ASSETTED ASSETTED ASSETTED ASSETTED ADDRIES, CITY, STATL, JIP CODE.  300 N MASHINGTON ST  **MAKARUSA, INA6673  **DAMACATUSA, I	ANDILAN	OF CORRECTION							
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snack *Assess food likes and dislikes  reviewed routinely by the nurse managers and any notation that		*Provide a nourishing HS (hour of sleep)							
*Assess food likes and dislikes managers and any notation that		snack							
*See nutritional plan of care" the pyxis machine has been		*Assess food lik	es and dislikes						
		*See nutritional	plan of care"			the pyxis machine has been			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		00				X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155582	A. BUI	LDING	00	09/27/2	
		100002	B. WIN			03/21/2	011
NAME OF I	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
MILLER'S	S MERRY MANOR				RUSA, IN46573		
		TATEMENT OF DEFICIENCIES	1	ID ID			(V.5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	The dietary note, resident was receprotein for low laptan indicated the hemoglobin and indicated he was and vitamin C for Review of the was resident's weight lbs on 8/20/11, to and 200.8 lbs on Nurses notes, daindicated "Noted that is covered was notes. Dr (physis new orders for direferral to wound Low air loss mate cushion placed in left for (daughten The wound assess was 5.5 cm by 3. The assessment is wanted to sit in her Review of the physis new orders for the wound assess was 5.5 cm by 3. The assessment is wanted to sit in her report indicated the physis new orders for the physis new of the phys	eiving double portions of abs. The nutritional care to resident had low hematocrit. The plan getting a bedtime snack ortified juice.  eight record indicated the towas stable from 196.8 to 199.6 lbs on 8/30/11, 9/20/11.  Ited 9/20/11 at 12:12 p.m., I area on right gluteal fold with escharsee wound cian's name) notified with ressing, supplement, and I md (medical doctor). Iteress applied and ROHO in wheelchair. Message of the call for updates."  Issement indicated the area as a second of the schar present. Indicated the resident in this wheelchair all day.			accessed will be reviewed by nurse manager to ensure medication/treatment was delivered as ordered. The unimanagers or other designee be responsible to complete the QA tool titled "Physician Order Review" (Attachment J) on a new orders daily for the next 14days, then on 10 new physorders for each seperate unit weekly for 30days, then 10 norders weekly for the next 6 months to ensure medication and treatments are administed per order. The QA tool "Physician Order Review" will include MAR/TAR review 3x weekly to ensure that existing medication and treatment or are available and delivered a ordered. Any identified issues be logged on a QA tracking leand reviewed during the morfacility QA meeting to monito ongoing compliance.	t will ne er ll sician ew as ered ll also g ders s es will og uthly	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	ILDING 00		COMPLETED	
	155582		B. WING 09/27/2011				011
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE		
					VASHINGTON ST		
MILLER'S MERRY MANOR				WAKAF	RUSA, IN46573		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		NATE COMPLETION	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)						
TAG			+	TAG	DEFICIENCI)	DATE	
	,	, the hemoglobin was low					
	at 10.8 (normal 13.0-17.3) and the						
	hematocrit was low at 34.5 (normal						
	39.0-53.0). The physician had ordered multivitamins with minerals and iron, on						
		ith minerals and iron, on					
	8/29/11.						
	Davious of the M	ledication Administration					
		For the months of August					
	` ′	•					
	_	2011, indicated the peen circled or not given					
		om 8/29 to 9/15/11. The					
	1	he back of the MAR					
		amin was not available.					
	indicated the vita	amm was not available.					
	During an interv	iew with the Director of					
	_	on 9/27/11 at 11:00 a.m.,					
		e had not been made					
		ation was not being given					
		with the pharmacy. The					
		ne pharmacy told her they					
		the order, and the					
		en sent until the nurse					
		1. The DoN checked the					
		g system) and found the					
	1	a available in the facility,					
		taken out for Resident					
	#B.	witer out for resident					
	" <b>D</b> .						
	Review of a seco	ond hemoglobin and					
		red by the physician to be					
	done 9/12/11, af						
	-						
	vitamin/mineral/iron supplement had been administered for a two week period,						
	administered for	a two week period,					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	N NUMBER:		A. BUILDING 00		COMPLETED	
		155582	B. WING			09/27/2011		
NAME OF I	PROVIDER OR SUPPLIEI	}	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF FROVIDER OR SUFFLIER					VASHINGTON ST			
MILLER'S	S MERRY MANOR			WAKAF	RUSA, IN46573			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG				TAG	DEFICIENCY)		DATE	
	indicated the hemoglobin remained at							
		natocrit was slightly better						
	at 34.8.							
		l also been diagnosed with						
	1	fection and started on the						
	antibiotic Cipro 500 mg, twice daily, of							
	10 days on 9/19/	11.						
	The care plan related to the skin							
	breakdown, dated 9/20/11, indicated							
	"supplemental v	itamins as ordered."						
	Review of albumin and prealbumin levels,							
	dated 9/22/11, ir	ndicated the resident's						
	albumin was lov	v at 2.9 (normal 3.5-5.2)						
	and the prealbun	nin was low at 10.0						
	(normal 20.0-40	.0). Prostat AWC						
	(nutritional supplement) was added twice daily 9/20/11.							
	The area on Res	ident B's gluteal area was						
	observed during	a dressing change, on						
	9/27/11 at 9:55 a	a.m., with LPN #9						
	measuring the ar	rea. The area was found						
	to be 5.6 cm by	3.5 cm with a depth of .3						
	cm. This was sli	ghtly larger than the						
	original area ide	ntified on 9/20/11.						
	During interview	v at that time, LPN #9						
	-	ysician had debrided the						
		ming on 9/28/11 to do						
		nent. Santyl and a						
		olied by RN #10.						
	1							

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155582	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING 00 COMPLETED  D. WING 09/27/2011		ETED		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	09/21/2	011
NAME OF PROVIDER OR SUPPLIER			300 N WASHINGTON ST				
MILLER'S MERRY MANOR				WAKAR	RUSA, IN46573		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA		DATE
	This federal tag relates to Complaint						
	IN00095676.						
	2.1.40(a)(1)						
	3.1-40(a)(1) 3.1-40(a)(2)						
	3.1 10(4)(2)						